PROPOSED RULE MAKING

CR-102 (June 2004)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Department of Social and Health Services, Health and Recovery Services Administration

☒ **Preproposal Statement of Inquiry was filed as WSR 05-17-140; or**	☒ **Original Notice**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**	☐ **Supplemental Notice to WSR**
☐ **Proposal is exempt under RCW 34.05.310(4).**	☐ **Continuance of WSR**

Title of rule and other identifying information: (Describe Subject)

Sections in Title 388 WAC regarding covered and noncovered services – Part 2 of 3

See "Attachment" for a list of the affected WAC sections.

Hearing location(s):

Blake Office Park East – Rose Room
4500 – 10th Ave. SE
Lacey, Washington 98503
(One block north of the intersection of Pacific Ave. SE and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling 360-664-6097)

Date: **November 7, 2006** Time: **10:00 a.m.**

Submit written comments to:

Name: DSHS Rules Coordinator
Address: PO Box 45850, Olympia WA, 98504
Delivery: 4500 – 10th Ave. SE, Lacey, Washington 98503
E-mail: fernaax@dshs.wa.gov Fax: (360) 664-6185
by **5:00 p.m. on November 7, 2006**

Date of intended adoption: Not earlier than November 8, 2006 (Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Stephanie Schiller, DSHS Rules Consultant by November 3, 2006
TTY (360) 664-6178 or (360) 664-6097 or
by e-mail at schilse@dshs.wa.gov

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

See "Attachment" for purpose and explanation of changes.

Reasons supporting proposal: It will make HRSA's rules regarding covered and noncovered medical services clearer and easier to understand for our clients and medical providers.

Statutory authority for adoption:
RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700

Statute being implemented:
RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

DATE 9/15/06

NAME (type or print)
Andy Fernando

SIGNATURE

TITLE
Manager, Rules and Policies Assistance Unit

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

SEP 19 2006

TIME 4:04 AM PM
WSR 06-19-099

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
None.

Name of proponent: (person or organization) Department of Social and Health Services

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Kevin Sullivan	626-8th Ave, Olympia, WA 98504-5504	(360) 725-1344
Implementation....	Gail Kreiger	" " "	(360) 725-1681
Enforcement.....	"	" " "	(360) 725-1681

Has a small business economic impact statement been prepared under chapter 19.85 RCW?

☐ Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( )
fax ( )
e-mail

☒ No. Explain why no statement was prepared.

This amendment does not create more than minor costs to small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

☒ Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name: Kevin Sullivan, HRSA Rules Coordinator
Address: P.O. Box 45504, Olympia, WA 98504-4405
Phone: (360) 725-1344 Fax: (360) 586-9727
E-mail: sullikm@dshs.wa.gov TYY/TDD: 1-800-848-5429

☐ No: Please explain:

Attachment to CR-102 (Part 2 of 3)
For Preproposal Statement of Inquiry filed as WSR 05-17-140

WAC Sections Proposed in Part 2:

Amending:
WAC 388-416-0015, Certification Periods for CN and SCHIP Medical Programs
WAC 388-475-1000, Healthcare for Workers with Disabilities (HWD) – Program Description
WAC 388-501-0180, Out-of-State Medical Care
WAC 388-519-0110, Spenddown of Excess Income for the Medically Needy Program
WAC 388-530-1000, Drug Program
WAC 388-530-1150, Noncovered Drugs and Pharmaceutical Supplies and Reimbursement Limitations
WAC 388-531-1600, Bariatric Surgery
WAC 388-533-0340, Maternity Support Services – Noncovered Services
WAC 388-533-0385, Infant Case Management – Noncovered Services
WAC 388-535-1265, Dental-Related Services Not Covered – Adults
WAC 388-535A-0040, Covered and Noncovered Orthodontic Services and Limitations to Coverage
WAC 388-538-063, Mandatory Enrollment in Managed Care for GAU Clients
WAC 388-538-095, Scope of Care for Managed Care Enrollees
WAC 388-540-130, Covered Services
WAC 388-540-140, Noncovered Services
WAC 388-540-150, Reimbursement – General
Repealing:
WAC 388-501-0300, Limits on Scope of Medical Program Services
WAC 388-529-0100, Scope of Covered Medical Services by Program
WAC 388-529-0200, Medical Services Available to Eligible Clients

Purpose of Rule Amendment

The purpose of the proposal is to:

- Improve the quality of care received by DSHS clients by using a consistent, evidence-based approach to making benefit coverage decisions.
- Make HRSA benefit coverage rules clearer, more transparent, and consistent.
- Establish a clear, transparent process by which HRSA determines what services are included under its benefit coverage.
- Maximize program resources through prudent use of cost-effective practices.

Changes to Rule in Parts 1, 2, and 3

In this proposal, the department has:

- Replaced "Medical Assistance Administration" and "MAA" with "the department" or "HRSA."
- Substituted WAC 388-501-0160 cross reference in place of WAC 388-501-0165 where noncovered services are addressed.
- Replaced all references to chapter 388-529 WAC with new WAC 388-501-0060 and WAC 388-501-0065.
- Added reference to new WAC 388-501-0169 in rules where limitations on covered services are addressed.
- Repealed chapter 388-529 WAC which is being replaced with WAC 388-501-0060 and WAC 388-501-0065.

Attachment to CR-102 (Part 2 of 3)
For Preproposal Statement of Inquiry filed as WSR 05-17-140

- Repealed WAC 388-501-0300 because it was incorporated into WAC 388-501-0050 and WAC 388-501-0070.
- Removed gender reassignment surgery from covered service status.
- More clearly defined what is covered and not covered in the way of cosmetic and reconstructive surgery, treatment, and procedures in WAC 388-531-0100 and new WAC 388-501-0070.
- Added more detail to WAC 388-501-0160 regarding the criteria and steps in the exception to rule (ETR) process.
- In new WAC 388-501-0065, added brief descriptions of services available under each category of service listed in the table in new WAC 388-501-0060.
- Included cross references (in new WAC 388-501-0065 and WAC 388-501-0070) to other program WACs where the reader can find more specific detail of the covered or noncovered service.
- Codified the evaluation criteria HRSA will use when evaluating requests for covered services beyond the maximum allowed.

AMENDATORY SECTION (Amending WSR 05-19-031, filed 9/12/05, effective 10/13/05)

WAC 388-416-0015 Certification periods for categorically needy (CN) medical and state children's health insurance program (SCHIP). (1) A certification period is the period of time a person is determined eligible for a categorically needy (CN) medical program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues to the last day of the last month of the certification period.

(2) For a child eligible for the newborn medical program, the certification period begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) For a woman eligible for a medical program based on pregnancy, the certification period ends the last day of the month that includes the sixtieth day from the day the pregnancy ends.

(4) For families the certification period is twelve months with a six-month report required as a condition of eligibility as described in WAC 388-418-0011.

(5) For children, the certification period is twelve months. Eligibility is continuous without regard to changes in circumstances other than aging out of the program, moving out of state or death. When the medical assistance unit is also receiving benefits under a cash or food assistance program, the medical certification period is updated to begin anew at each:

(a) Approved application for cash or food assistance; or

(b) Completed eligibility review.

(6) For an SSI-related person the certification period is twelve months.

(7) When the child turns nineteen the certification period ends even if the twelve-month period is not over. The certification period may be extended past the end of the month the child turns nineteen when:

(a) The child is receiving inpatient services on the last day of the month the child turns nineteen;

(b) The inpatient stay continues into the following month or months; and

(c) The child remains eligible except for exceeding age nineteen.

(8) A retroactive certification period can begin up to three months immediately before the month of application when:

(a) The client would have been eligible for medical assistance if the client had applied; and

(b) The client received covered medical services as described in WAC ((~~388-529-0100~~)) 388-501-0060 and WAC 388-501-0065.

(9) If the client is eligible only during the three-month retroactive period, that period is the only period of certification.

(10) Any months of a retroactive certification period are added to the designated certification periods described in this section.

(11) For a child determined eligible for SCHIP medical benefits as described in chapter 388-542 WAC:

(a) The certification periods are described in subsections (1), (5), and (7) of this section;

(b) There is not a retroactive eligibility period as described in subsections (8), (9), and (10); and

(c) For a child who has creditable coverage at the time of application, the certification period begins on the first of the month after the child's creditable coverage is no longer in effect, if:

(i) All other SCHIP eligibility factors are met; and

(ii) An eligibility decision is made per WAC 388-406-0035.

AMENDATORY SECTION (Amending WSR 02-01-073, filed 12/14/01, effective 1/14/02)

WAC 388-475-1000 Healthcare for workers with disabilities (HWD)--Program description. This section describes the healthcare for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) ((~~Medicaid services~~)) scope of care as described in WAC 3((~~88-529-0200~~)) 388-501-0060.

(2) The department approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 388-475-1100 for "retroactive" coverage for months before the month of application.

(3) A person who is eligible for another Medicaid program may choose not to participate in the HWD program.

(4) A person is not eligible for HWD coverage for a month in which the person received Medicaid benefits under the medically needy (MN) program.

(5) The HWD program does not provide long-term care (LTC) services described in chapters 388-513 and 388-515 WAC. LTC services include institutional, waivered, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.

AMENDATORY SECTION (Amending WSR 01-01-011, filed 12/6/00, effective 1/6/01)

WAC 388-501-0180 Out-of-state medical care. (1) The department ((~~of social and health services (DSHS)~~)) considers cities bordering Washington state and listed in WAC 388-501-0175 the same as in-state cities for:

(a) Medical care coverage under all medical programs administered by the ((~~medical assistance administration (MAA)~~)) department; and

(b) Reimbursement purposes.

(2) The department does not cover out-of-state medical care for clients under the following state-administered (Washington state medical care only) medical programs:

(a) General assistance-unemployable (GA-U); or

(b) Alcohol and Drug Addiction Treatment and Support Act (ADATSA) ((~~; or~~

~~(c) Medically indigent program (MIP)~~)).

(3) Subject to the exceptions and limitations in this section, the department covers out-of-state medical care provided to eligible clients when the services are:

(a) Within the scope of the client's medical care program as specified ((~~under chapter 388-529~~)) in WAC 388-501-0060; and

(b) Medically necessary as defined in WAC 388-500-0005.

(4) If the client travels out-of-state expressly to obtain medical care, the medical services must have prior authorization through the department's determination process described in WAC 388-501-0165.

(5) See WAC 388-501-0165 for the department's determination process for requests for:

(a) ((~~Any service that is listed in any Washington Administrative Code section as noncovered;~~

~~(b)~~)) A service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550; ((~~and~~)) or

((~~(c)~~)) (b) A covered service that is subject to the department's limitations or other restrictions and the request for the service exceeds those limitations or restrictions (see also WAC 388-501-0169).

(6) The department evaluates a request for a noncovered service if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(7) The department determines out-of-state coverage for transportation services, including ambulance services, according to chapter 388-546 WAC.

((~~(7)~~)) (8) The department reimburses an out-of-state provider for medical care provided to an eligible client if the provider:

(a) Meets the licensing requirements of the state in which care is provided;

(b) Contracts with the department to be an enrolled provider; and

(c) Meets the same criteria for payment as in-state providers.

AMENDATORY SECTION (Amending WSR 06-13-042, filed 6/15/06, effective 7/16/06)

WAC 388-519-0110 Spenddown of excess income for the medically needy program. (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown

calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for medical services either paid or unpaid and incurred during the base period; or

(iii) Be for medical services paid and incurred during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in ((~~chapter 388-529~~)) WAC 388-501-0060 and WAC 388-501-0065, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses for services rendered to the client must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) The medical expenses applied to the spenddown amount are the client's financial obligation and are not reimbursed by the department (see WAC 388-502-0100).

(16) Once a person meets their spenddown and they are issued

a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a clients failure to identify or list medical expenses.

AMENDATORY SECTION (Amending WSR 02-17-023, filed 8/9/02, effective 9/9/02)

WAC 388-530-1000 ((~~The medical assistance administration (MAA)~~)) Drug program. (1) The ((~~medical assistance administration (MAA)~~)) department reimburses providers for prescription drugs and pharmaceutical supplies according to department rules and subject to the exceptions and restrictions listed in this chapter.

(2) ((~~MAA~~)) The department reimburses only pharmacies that:

(a) Are ((~~MAA-enrolled~~)) department-enrolled providers; and

(b) Meet the general requirements for providers described under WAC 388-502-0020.

(3) To be both covered and reimbursed under this chapter, prescription drugs must be:

(a) Medically necessary as defined in WAC 388-500-0005;

(b) Within the scope of coverage of an eligible client's medical assistance program. Refer to ((~~chapter 388-529~~)) WAC 388-501-0060 and WAC 388-501-0065 for scope of coverage information;

(c) For a medically accepted indication appropriate to the client's condition;

(d) Billed according to the conditions under WAC 388-502-0150 and 388-502-0160; and

(e) Billed according to the conditions and requirements of this chapter.

(4) Acceptance and filling of a prescription for a client eligible for a medical care program constitutes acceptance of ((~~MAA's~~)) the department's rules and fees. See WAC 388-502-0100 for general conditions of payment.

AMENDATORY SECTION (Amending WSR 05-02-044, filed 12/30/04, effective 1/30/05)

WAC 388-530-1150 Noncovered drugs and pharmaceutical supplies and reimbursement limitations. (1) The ((~~medical assistance administration (MAA)~~)) department does not cover:

(a) Brand or generic drugs, when the manufacturer has not signed a rebate agreement with the federal Department of Health and Human Services. Refer to WAC 388-530-1125 for information on the drug rebate program.

(b) A drug prescribed:

(i) For weight loss or gain;

(ii) For infertility, frigidity, impotency, or sexual dysfunction;

(iii) For cosmetic purposes or hair growth; or

(iv) To promote tobacco cessation, except as described in WAC 388-533-0345 (3)(d) tobacco cessation for pregnant women.

(c) Over-the-counter (OTC) drugs and supplies, except as described under WAC 388-530-1100.

(d) Prescription vitamins and mineral products, except:

(i) When prescribed for clinically documented deficiencies;

(ii) Prenatal vitamins, only when prescribed and dispensed to pregnant women; or

(iii) Fluoride preparations for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

(e) A drug prescribed for an indication or dosing that is not evidence based as determined by:

(i) ((~~MAA~~)) The department in consultation with federal guidelines; or

(ii) The drug use review (DUR) board; and

(iii) ((~~MAA~~)) The department's medical consultants and ((~~MAA~~)) the department's pharmacist(s).

(f) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(g) Drugs that are:

(i) Not approved by the Food and Drug Administration (FDA); or

(ii) Prescribed for non-FDA approved indications or dosing, unless prior authorized; or

(iii) Unproven for efficacy or safety.

(h) Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

(i) Drugs requiring prior authorization for which ((~~MAA~~)) department authorization has been denied.

(j) Preservatives, flavoring and/or coloring agents.

(k) Less than a one-month supply of drugs for long-term therapy.

(l) A drug with an obsolete national drug code (NDC) more than two years from the date the NDC is designated obsolete by the manufacturer.

(m) Products or items that do not have an eleven-digit NDC.

(n) Nonpreferred drugs when a therapeutic equivalent is on the preferred drug list(s) (PDL), according to WAC 388-530-1100, and subject to the dispense as written (DAW) provisions of WAC 388-530-1280, and 388-530-1290.

(o) Less than a three-month supply of contraceptive patches, contraceptive rings, or oral contraceptives (excluding emergency contraceptive pills), unless otherwise directed by the prescriber.

(2) ((~~MAA~~)) The department does not reimburse enrolled providers for:

(a) Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

(i) Diagnosis-related group (DRG);

(ii) Ratio of costs-to-charges (RCC);

(iii) Nursing facility ((~~per diem~~)) daily rate;
(iv) Managed care capitation rates;
(v) Block grants; or
(vi) Drugs prescribed for clients who are on the ((~~MAA~~)) department's hospice program when the drugs are related to the client's terminal illness and related condition(s).

(b) Any drug regularly supplied as an integral part of program activity by other public agencies (e.g., immunization vaccines for children).

(c) Prescriptions written on pre-signed prescription blanks filled out by nursing facility operators or pharmacists. ((~~MAA~~)) The department may terminate the core provider agreement of pharmacies involved in this practice.

(d) Drugs used to replace those taken from nursing facility emergency kits.

(e) Drugs used to replace a physician's stock supply.

(f) Free pharmaceutical samples.

(g) A drug product after the product's national drug code (NDC) termination date.

(h) A drug product whose shelf life has expired.

(3) ((~~MAA~~)) The department evaluates each request for authorization of a noncovered drug ((~~under WAC 388-530-1100(5) and under the provisions of WAC 388-501-0165~~)), device, or pharmaceutical supply as an exception to rule according to WAC 388-501-0160.

AMENDATORY SECTION (Amending WSR 05-12-022, filed 5/20/05, effective 6/20/05)

WAC 388-531-1600 Bariatric surgery. (1) The ((~~medical assistance administration (MAA)~~)) department covers medically necessary bariatric surgery for eligible clients.

(2) Bariatric surgery must be performed in a hospital with a bariatric surgery program, and the hospital must be:

(a) Located in the state of Washington or approved border cities (see WAC 388-501-0175); and

(b) Meet the requirements of WAC 388-550-2301.

(3) If bariatric surgery is requested or prescribed under the EPSDT program, ((~~MAA~~)) the department evaluates it as a covered service under EPSDT's standard of coverage that requires the service to be:

(a) Medically necessary;

(b) Safe and effective; and

(c) Not experimental.

(4) ((~~MAA~~)) The department authorizes payment for bariatric surgery and bariatric surgery-related services in three stages:

(a) Stage one--Initial assessment of client;

(b) Stage two--Evaluations for bariatric surgery and successful completion of a weight loss regimen; and

(c) Stage three--Bariatric surgery.

Stage one--Initial assessment

(5) Any ((~~MAA~~)) department-enrolled provider who is licensed

to practice medicine in the state of Washington may examine a client requesting bariatric surgery to ascertain if the client meets the criteria listed in subsection (6) of this section.

(6) The client meets the preliminary conditions of stage one when:

(a) The client is between twenty-one and fifty-nine years of age;

(b) The client has a body mass index (BMI) of thirty-five or greater;

(c) The client is not pregnant. (Pregnancy within the first two years following bariatric surgery is not recommended. When applicable, a family planning consultation is highly recommended prior to bariatric surgery.);

(d) The client is diagnosed with one of the following:

(i) Diabetes mellitus;

(ii) Degenerative joint disease of a major weight bearing joint(s) (the client must be a candidate for joint replacement surgery if weight loss is achieved); or

(iii) Other rare comorbid conditions (such as pseudo tumor cerebri) in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality; and

(e) The client has an absence of other medical conditions such as multiple sclerosis (MS) that would increase the client's risk of surgical mortality or morbidity from bariatric surgery.

(7) If a client meets the criteria in subsection (6) of this section, the provider must request prior authorization from ((~~MAA~~)) the department before referring the client to stage two of the bariatric surgery authorization process. The provider must attach a medical report to the request for prior authorization with supporting documentation that the client meets the stage one criteria in subsections (5) and (6) of this section.

(8) ((~~MAA~~)) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the ((~~standards for covered services in~~)) provisions of WAC 388-501-0165 and WAC 388-501-0169.

Stage two--Evaluations for bariatric surgery and successful completion of a weight loss regimen

(9) After receiving prior authorization from ((~~MAA~~)) the department to begin stage two of the bariatric surgery authorization process, the client must:

(a) Undergo a comprehensive psychosocial evaluation performed by a psychiatrist, licensed psychiatric ARNP, or licensed independent social worker with a minimum of two years postmasters' experience in a mental health setting. Upon completion, the results of the evaluation must be forwarded to ((~~MAA~~)) the department. The comprehensive psychosocial evaluation must include:

(i) An assessment of the client's mental status or illness to:

(A) Evaluate the client for the presence of substance abuse problems or psychiatric illness which would preclude the client from participating in presurgical dietary requirements or postsurgical lifestyle changes; and

(B) If applicable, document that the client has been successfully treated for psychiatric illness and has been

stabilized for at least six months and/or has been rehabilitated and is free from any drug and/or alcohol abuse and has been drug and/or alcohol free for a period of at least one year.

(ii) An assessment and certification of the client's ability to comply with the postoperative requirements such as lifelong required dietary changes and regular follow-up.

(b) Undergo an internal medicine evaluation performed by an internist to assess the client's preoperative condition and mortality risk. Upon completion, the internist must forward the results of the evaluation to ((~~MAA~~)) the department.

(c) Undergo a surgical evaluation by the surgeon who will perform the bariatric surgery (see subsection (13) of this section for surgeon requirements). Upon completion, the surgeon must forward the results of the surgical evaluation to ((~~MAA~~)) the department and to the licensed medical provider who is supervising the client's weight loss regimen (refer to WAC 388-531-1600 (9)(d)(ii)).

(d) Under the supervision of a licensed medical provider, the client must participate in a weight loss regimen prior to surgery. The client must, within one hundred and eighty days from the date of ((~~MAA's~~)) the department's stage one authorization, lose at least five percent of his or her initial body weight. If the client does not meet this weight loss requirement within one hundred and eighty days from the date of ((~~MAA's~~)) the department's initial authorization, ((~~MAA~~)) the department will cancel the authorization. The client or the client's provider must reapply for prior authorization from ((~~MAA~~)) the department to restart stage two. For the purpose of this section, "initial body weight" means the client's weight at the first evaluation appointment.

(i) The purpose of the weight loss regimen is to help the client achieve the required five percent loss of initial body weight prior to surgery and to demonstrate the client's ability to adhere to the radical and lifelong behavior changes and strict diet that are required after bariatric surgery.

(ii) The weight loss regimen must:

(A) Be supervised by a licensed medical provider who has a core provider agreement with ((~~MAA~~)) the department;

(B) Include monthly visits to the medical provider;

(C) Include counseling twice a month by a registered dietician referred to by the treating provider or surgeon; and

(D) Be at least six months in duration.

(iii) Documentation of the following requirements must be retained in the client's medical file. Copies of the documentation must be forwarded to ((~~MAA~~)) the department upon completion of stage two. ((~~MAA~~)) The department will evaluate the documentation and authorize the client for bariatric surgery if the stage two requirements were successfully completed.

(A) The provider must document the client's compliance in keeping scheduled appointments and the client's progress toward weight loss by serial weight recordings. Clients must lose at least five percent loss of initial body weight and must maintain the five percent weight loss until surgery;

(B) For diabetic clients, the provider must document the efforts in diabetic control or stabilization;

(C) The registered dietician must document the client's compliance (or noncompliance) in keeping scheduled appointments,

and the client's weight loss progress;

(D) The client must keep a journal of active participation in the medically structured weight loss regimen including the activities under (d)(iii)(A), (d)(iii)(B) if appropriate, and (d)(iii)(C) of this subsection.

(10) If the client fails to complete all of the requirements of subsection (9) of this section, ((~~MAA~~)) the department will not authorize stage three--Bariatric surgery.

(11) If the client is unable to meet all of the stage two criteria, the client or the client's provider must reapply for prior authorization from ((~~MAA~~)) the department to re-enter stage two.

Stage three--Bariatric surgery

(12) ((~~MAA~~)) The department may withdraw authorization of payment for bariatric surgery at any time up to the actual surgery if ((~~MAA~~)) the department determines that the client is not complying with the requirements of this section.

(13) A surgeon who performs bariatric surgery for medical assistance clients must:

(a) Have a signed core provider agreement with ((~~MAA~~)) the department;

(b) Have a valid medical license in the state of Washington; and

(c) Be affiliated with a bariatric surgery program that meets the requirements of WAC 388-550-2301.

(14) For hospital requirements for stage three--Bariatric surgery, see WAC 388-530-2301.

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0340 Maternity support services--Noncovered services. (1) The following are considered noncovered services under the MSS program. Any service:

(a) Not within the scope of the program;

(b) Not listed in WAC 388-533-0330; or

(c) Any service provided by staff not qualified to deliver the service.

(2) ((~~MAA~~)) The department evaluates requests for services listed as noncovered under the provisions of WAC ((~~388-501-0165~~)) 388-501-0160.

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0385 Infant case management--Noncovered services. (1) The following services are ((~~considered~~)) noncovered

((~~services~~)) under the infant case management (ICM) program:

(a) Any direct delivery of services other than case management activities listed in WAC 388-533-0380(2); and

(b) Any service provided by staff not qualified to deliver the service.

(2) ((~~MAA~~)) The department evaluates requests for services listed as noncovered under the provisions of WAC ((~~388-501-0165~~)) 388-501-0160.

AMENDATORY SECTION (Amending WSR 03-19-079, filed 9/12/03, effective 10/13/03)

WAC 388-535-1265 Dental-related services not covered--Adults. (1) The ((~~medical assistance administration (MAA)~~)) department does not cover dental-related services ((~~for adults~~)), described in subsection (2) of this section, for adults unless the services are included in ((~~an MAA waivered~~)) a department waiver program.

(2) ((~~MAA~~)) The department does not cover the following dental-related services for adults:

(a) Any service specifically excluded by statute.

(b) More costly services when less costly, equally effective services as determined by the department are available.

(c) Services, procedures, treatment, devices, drugs, or application of associated services which the department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the services were provided.

(d) Coronal polishing.

(e) Fluoride treatments (gel or varnish) for adults, unless the clients are:

(i) Clients of the division of developmental disabilities;

(ii) Diagnosed with xerostomia, in which case the provider must request prior authorization; or

(iii) High-risk adults sixty-five and older. High-risk means the client has at least one of the following:

(A) Rampant root surface decay; or

(B) Xerostomia.

(f) Restorations for wear on any surface of any tooth without evidence of decay through the enamel or on the root surface.

(g) Flowable composites for interproximal or incisal restorations.

(h) Any permanent crowns, temporary crowns, or crown post and cores.

(i) Bridges, including abutment teeth and pontics.

(j) Root canal services for primary teeth.

(k) Root canal services for permanent teeth other than teeth six, seven, eight, nine, ten, eleven, twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven.

(l) Pulpotomy services for permanent teeth.

(m) Transitional or treatment dentures.

(n) Overdentures.

(o) Replacements for:

(i) Immediate maxillary or mandibular dentures;

(ii) Maxillary or mandibular partial dentures (resin); or

(iii) Complete maxillary or mandibular dentures in excess of one replacement in a ten-year period; or

(iv) Cast metal framework maxillary or mandibular partial dentures in excess of one replacement in a ten-year period.

(p) Rebasing of complete and immediate dentures and partial dentures.

(q) Adjustments of complete and immediate dentures and partial dentures.

(r) Tooth implants, including insertion, postinsertion, maintenance, and implant removal.

(s) Periodontal bone grafts or oral soft tissue grafts.

(t) Gingivectomy, gingivoplasty, or frenectomy, frenoplasty and other periodontal surgical procedures.

(u) Crown lengthening procedures.

(v) Orthotic appliances, including but not limited to, night guards, tempormandibular joint dysfunction (TMJ/TMD) appliances, and all other mouth guards.

(w) Any treatment of TMJ/TMD.

(x) Extraction of:

(i) Asymptomatic teeth;

(ii) Asymptomatic wisdom teeth; and

(iii) Surgical extraction of anterior teeth seven, eight, nine, ten, twenty-three, twenty-four, twenty-five, or twenty-six, which are considered simple extractions and paid as such.

(y) Alveoloplasty, alveoloectomy or tori, exostosis removal.

(z) Debridement of granuloma or cyst associated with tooth extraction.

(aa) Cosmetic treatment or surgery, except as prior authorized by the department for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness.

(bb) Nonemergent oral surgery for adults performed in an inpatient hospital setting, except:

(i) Nonemergent oral surgery is covered in an inpatient hospital setting for clients of the division of developmental disabilities when written prior authorization is obtained for the inpatient hospitalization; or

(ii) As provided in WAC 388-535-1080(4).

(cc) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners.

(dd) Dentist's time writing and calling in prescriptions or prescription refills.

(ee) Educational supplies.

(ff) Missed or canceled appointments.

(gg) Nonmedical equipment, supplies, personal or comfort items or services.

(hh) Provider mileage or travel costs.

(ii) Service charges or delinquent payment fees.

(jj) Supplies used in conjunction with an office visit.

(kk) Take-home drugs.

(ll) Teeth whitening.

(3) ((~~MAA~~)) The department evaluates a request for any dental-related service((~~s~~)) that ((~~are not~~)) is listed as noncovered ((~~or are in excess of the dental services program's~~

~~limitations or restrictions, according to WAC 388-501-0165~~)) under the provisions of WAC 388-501-0160.

(4) The department evaluates a request for a covered service in excess of the dental program's service limitations or restrictions according to the provisions of WAC 388-501-0169.

AMENDATORY SECTION (Amending WSR 05-01-064, filed 12/8/04, effective 1/8/05)

WAC 388-535A-0040 Covered and noncovered orthodontic services and limitations to coverage. (1) Subject to the limitations in this section and other applicable WAC, the ((~~medical assistance administration (MAA)~~)) department covers orthodontic treatment for a client who has one of the following medical conditions:

(a) Cleft lip, cleft palate, or other craniofacial anomalies when the client is treated by and receives follow-up care from a department-recognized craniofacial team for:

(i) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement;

(ii) Craniofacial anomalies, including but not limited to:

(A) Hemifacial microsomia;

(B) Craniosynostosis syndromes;

(C) Cleidocranial dental dysplasia;

(D) Arthrogryposis; or

(E) Marfan syndrome.

(iii) Other medical conditions with significant facial growth impact (e.g., juvenile rheumatoid arthritis (JRA)); or

(iv) Post-traumatic, post-radiation, or post-burn jaw deformity.

(b) Other severe handicapping malocclusions, including one or more of the following:

(i) Deep impinging overbite when lower incisors are destroying the soft tissues of the palate;

(ii) Crossbite of individual anterior teeth when destruction of the soft tissue is present;

(iii) Severe traumatic malocclusion (e.g., loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology);

(iv) Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties; or

(v) Medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score that result in a score of twenty-five or higher. On a case-by-case basis, ((~~MAA~~)) the department reviews all requests for treatment for conditions that result in a score of less than twenty-five, based on medical necessity.

(2) ((~~MAA~~)) The department may cover requests for orthodontic treatment for dental malocclusions other than those listed in subsection (1) of this section when ((~~MAA~~)) the department determines that the treatment is medically necessary.

(3) ((~~MAA~~)) The department does not cover:

(a) Lost or broken orthodontic appliances;

(b) Orthodontic treatment for cosmetic purposes;

(c) Orthodontic treatment that is not medically necessary (see WAC 388-500-0005);

(d) Out-of-state orthodontic treatment; or

(e) Orthodontic treatment and orthodontic-related services that do not meet the requirements of this section or other applicable WAC.

(4) ((~~MAA~~)) The department covers the following orthodontic treatment and orthodontic-related services, subject to the limitations listed (providers must bill for these services according to WAC 388-535A-0060):

(a) Panoramic radiographs (X rays), once per client in a three-year period.

(b) Interceptive orthodontic treatment, once per the client's lifetime.

(c) Limited transitional orthodontic treatment, up to one year from date of original appliance placement (see subsection (5) of this section for information on limitation extensions).

(d) Comprehensive full orthodontic treatment, up to two years from the date of original appliance placement (see subsection (5) of this section for information on limitation extensions).

(e) Orthodontic appliance removal only when:

(i) The client's appliance was placed by a different provider; and

(ii) The provider has not furnished any other orthodontic treatment to the client.

(f) Other medically necessary orthodontic treatment and orthodontic-related services as determined by ((~~MAA~~)) the department.

(5) A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. ((~~MAA~~)) The department evaluates and approves requests for LE for orthodontic services when medically necessary, under the provisions of WAC 388-501-0165.

(6) ((~~MAA~~)) The department evaluates a request for any orthodontic service not listed as covered in this section under the provisions of WAC ((~~388-501-0165~~)) 388-501-0160.

(7) ((~~MAA~~)) The department reviews requests for orthodontic treatment for clients who are eligible for services under the EPSDT program according to the provisions of WAC 388-534-0100.

AMENDATORY SECTION (Amending WSR 06-03-081, filed 1/12/06, effective 2/12/06)

WAC 388-538-063 Mandatory enrollment in managed care for GAU clients. (1) The purpose of this section is to describe the department's managed care requirement for general assistance unemployable (GAU) clients mandated by the Laws of 2003, chapter 25, section 209(15).

(2) The only sections of chapter 388-538 WAC that apply to GAU

clients described in this section are incorporated by reference into this section.

(3) To receive department-paid medical care, GAU clients must enroll in a managed care plan as required by WAC 388-505-0110(7) when they reside in a county designated as a mandatory managed care plan county.

(4) GAU clients are exempt from mandatory enrollment in managed care if they:

(a) Are American Indian or Alaska Native (AI/AN); and

(b) Meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants.

(5) In addition to subsection (4), the department will exempt a GAU client from mandatory enrollment in managed care or end an enrollee's enrollment in managed care in accordance with WAC 388-538-130(3) and 388-538-130(4).

(6) On a case-by-case basis, the department may grant a GAU client's request for exemption from managed care or a GAU enrollee's request to end enrollment when, in the department's judgment:

(a) The client or enrollee has a documented and verifiable medical condition; and

(b) Enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(7) The department enrolls GAU clients in managed care effective on the earliest possible date, given the requirements of the enrollment system. The department does not enroll clients in managed care on a retroactive basis.

(8) Managed care organizations (MCOs) that contract with the department to provide services for GAU clients must meet the qualifications and requirements in WAC 388-538-067 and 388-538-095 (3)(a), (b), (c), and (d).

(9) The department pays MCOs capitated premiums for GAU enrollees based on legislative allocations for the GAU program.

(10) GAU enrollees are eligible for the scope of care as described in WAC ((~~388-529-0200~~)) 388-501-0060 for medical care services (MCS) programs. Other scope of care provisions that apply:

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005;

(b) MCOs cover the services included in the managed care contract for GAU enrollees. MCOs may, at their discretion, cover services not required under the MCO's contract for GAU enrollees;

(c) The department pays providers on a fee-for-service basis for the medically necessary, covered medical care services not covered under the MCO's contract for GAU enrollees; and

(d) A GAU enrollee may obtain emergency services in accordance with WAC 388-538-100.

(11) The department does not pay providers on a fee-for-service basis for services covered under the MCO's contract for GAU enrollees, even if the MCO has not paid for the service, regardless of the reason. The MCO is solely responsible for payment of MCO-contracted health care services that are:

(a) Provided by an MCO-contracted provider; or

(b) Authorized by the MCO and provided by nonparticipating providers.

(12) The following services are not covered for GAU enrollees unless the MCO chooses to cover these services at no additional cost to the department:

(a) Services that are not medically necessary;

(b) Services not included in the medical care services scope of care;

(c) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions; and

(d) Services received from a nonparticipating provider requiring prior authorization from the MCO that were not authorized by the MCO.

(13) A provider may bill a GAU enrollee for noncovered services described in subsection (12), if the requirements of WAC 388-502-0160 and 388-538-095(5) are met.

(14) The grievance and appeal process found in WAC 388-538-110 applies to GAU enrollees described in this section.

(15) The hearing process found in chapter 388-02 WAC and WAC 388-538-112 applies to GAU enrollees described in this section.

AMENDATORY SECTION (Amending WSR 06-03-081, filed 1/12/06, effective 2/12/06)

WAC 388-538-095 Scope of care for managed care enrollees. (1) Managed care enrollees are eligible for the scope of medical care as described in WAC ((~~388-529-0100~~)) 388-501-0060 for categorically needy clients.

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the MCO contract for MCO enrollees. MCOs may, at their discretion, cover additional services not required under the MCO contract. However, the department may not require the MCO to cover any additional services outside the scope of services negotiated in the MCO's contract with the department.

(c) The department covers medically necessary ((~~categorically needy~~)) services described in ((~~chapter 388-529~~)) WAC 388-501-0060 and WAC 388-501-0065 that are excluded from coverage in the MCO contract.

(d) The department covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee or refer the enrollee to other providers who are contracted with the department for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. The services that require PCCM provider referral are described in the PCCM contract. The department informs enrollees about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

(e) MCO enrollees may obtain certain services from either an

MCO provider or from a ((~~medical assistance provider with a~~)) department-enrolled provider with a current core provider agreement without needing to obtain a referral from the PCP or MCO. These services are described in the managed care contract, and are communicated to enrollees by the department and MCOs as described in (f) of this subsection.

(f) The department sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by the department, and which services are covered by MCOs. In addition, the department requires MCOs to provide new enrollees with written information about covered services.

(2) For services covered by the department through PCCM contracts for managed care:

(a) The department covers medically necessary services included in the categorically needy scope of care and rendered by providers who have a current core provider agreement with the department to provide the requested service;

(b) The department may require the PCCM provider to obtain authorization from the department for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) An enrollee may request a hearing for review of PCCM provider or the department coverage decisions (see WAC 388-538-110); and

(e) Services referred by the PCCM provider require an authorization number in order to receive payment from the department.

(3) For services covered by the department through contracts with MCOs:

(a) The department requires the MCO to subcontract with a sufficient number of providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) The department requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(d) MCOs and their providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;

(e) The department requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;

(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100 from any women's health care provider participating with the MCO. Any covered services ordered and/or prescribed by the women's health care provider must meet the MCO's service authorization requirements for the specific service.

(g) For enrollees temporarily outside their MCOs service area, the MCO is required to cover enrollees for up to ninety days for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their service area.

(4) Unless the MCO chooses to cover these services, or an appeal, independent review, or a hearing decision reverses an MCO or department denial, the following services are not covered:

(a) For all managed care enrollees:

(i) Services that are not medically necessary;

(ii) Services not included in the categorically needy scope of services; and

(iii) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions.

(b) For MCO enrollees:

(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO; and

(ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

(c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.

(5) A provider may bill an enrollee for noncovered services as described in subsection (4) of this section, if the requirements of WAC 388-502-0160 are met. The provider must give the original agreement to the enrollee and file a copy in the enrollee's record.

(a) The agreement must state all of the following:

(i) The specific service to be provided;

(ii) That the service is not covered by either the department or the MCO;

(iii) An explanation of why the service is not covered by the MCO or the department, such as:

(A) The service is not medically necessary; or

(B) The service is covered only when provided by a participating provider.

(iv) The enrollee chooses to receive and pay for the service; and

(v) Why the enrollee is choosing to pay for the service, such as:

(A) The enrollee understands that the service is available at no cost from a provider participating with the MCO, but the enrollee chooses to pay for the service from a provider not participating with the MCO;

(B) The MCO has not authorized emergency department services for nonemergency medical conditions and the enrollee chooses to pay for the emergency department's services rather than wait to receive services at no cost in a participating provider's office; or

(C) The MCO or PCCM has determined that the service is not medically necessary and the enrollee chooses to pay for the service.

(b) For ((~~limited-English proficient~~)) enrollees <u>with limited English proficiency</u>, the agreement must be translated or

interpreted into the enrollee's primary language to be valid and enforceable.

(c) The agreement is void and unenforceable, and the enrollee is under no obligation to pay the provider, if the service is covered by the department or the MCO as described in subsection (1) of this section, even if the provider is not paid for the covered service because the provider did not satisfy the payor's billing requirements.

AMENDATORY SECTION (Amending WSR 03-21-039, filed 10/8/03, effective 11/8/03)

WAC 388-540-130 Covered services. (1) The ((~~medical assistance administration (MAA)~~)) department covers the following services and supplies subject to the restrictions and limitations in this section and other applicable published WAC:

(a) In-facility dialysis;
(b) Home dialysis;
(c) Training for self-dialysis;
(d) Home dialysis helpers;
(e) Dialysis supplies;
(f) Diagnostic lab work;
(g) Treatment for anemia; and
(h) Intravenous drugs.

(2) Covered services are subject to the limitations specified by ((~~MAA~~)) the department. Providers must obtain prior authorization (PA) or expedited prior authorization (EPA) before providing services that exceed specified limits in quantity, frequency or duration (refer to WAC 388-501-0165 ((~~for the PA process~~)) and WAC 388-501-0169).

AMENDATORY SECTION (Amending WSR 03-21-039, filed 10/8/03, effective 11/8/03)

WAC 388-540-140 Noncovered services. (1) The ((~~medical assistance administration (MAA)~~)) department does not reimburse kidney centers for the following:

(a) Blood and blood products (refer to WAC 388-540-190);
(b) Personal care items such as slippers, toothbrushes, etc.; or
(c) Additional staff time or personnel costs. Staff time is paid through the composite rate. Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 388-540-160).

(2) ((~~MAA reviews all initial requests~~)) The department evaluates a request for any service listed as noncovered ((~~services based on WAC 388-501-0165~~)) in this chapter under the provisions of WAC 388-501-0160.

AMENDATORY SECTION (Amending WSR 03-21-039, filed 10/8/03, effective 11/8/03)

WAC 388-540-150 Reimbursement--General. (1) Kidney center services described in this section are paid by one of two methods:

(a) **Composite rate payments--**This is a payment method in which all standard equipment, supplies and services are calculated into a blended rate.

(i) A single dialysis session and related services are reimbursed through a single composite rate payment (refer to WAC 388-540-160).

(ii) Composite rate payments for continuous ambulatory peritoneal dialysis (CAPD) or continuous cycling peritoneal dialysis (CCPD) are limited to thirty-one per month for an individual client.

(iii) Composite rate payments for all other types of dialysis sessions are limited to fourteen per month for an individual client.

(b) **Noncomposite rate payments--**End-stage renal disease (ESRD) services and items covered by the ((~~medical assistance administration (MAA)~~)) department but not included in the composite rate are billed and paid separately (refer to WAC 388-540-170).

(2) **Limitation extension request--**((~~MAA~~)) The department evaluates billings for covered services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions when medically necessary((~~,~~)) under the ((~~standards~~)) provisions of WAC 388-501-0165 and WAC 388-501-0169.

(3) **Take-home drugs--**((~~MAA~~)) The department reimburses kidney centers for take-home drugs only when they meet the conditions described in WAC 388-540-170(1). Other drugs for at-home use must be billed by a pharmacy and be subject to ((~~MAA~~)) the department's pharmacy rules.

(4) **Medical nutrition--**Medical nutrition products must be billed by a pharmacy or a durable medical equipment (DME) provider.

(5) **Medicare eligible clients--**((~~MAA~~)) The department does not reimburse kidney centers as a primary payer for Medicare eligible clients.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-501-0300	Limits on scope of medical program services.

WAC 388-529-0100	Scope of covered medical services by program.
WAC 388-529-0200	Medical services available to eligible clients.